DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING 02, 03		(X3) DATE SURVEY COMPLETED	
	15G307 B. WING			11/19/2013			
NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCES SRV INC				STREET ADDRESS, CITY, STATE, ZIP CODE 206 W STATE ST KINGMAN, IN 47952			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
K 000	INITIAL COMMENTS		K	000			
	conducted by the Ind	ecertification Survey was an a State Department of with 42 CFR 483.470(j).					
	Survey Date: 11/19/1	3					
	Facility Number: 000 Provider Number: 15 AIM Number: 10024	G307					
	Surveyor: Bridget Bri Specialist	own, Life Safety Code					
	Resource Services In with Requirements fo 42 CFR Subpart 483 and the 2000 edition Protection Associatio Code (LSC), Chapter	n (NFPA) 101, Life Safety 33, Existing Residential upancies for the original					
	the addition of a north 2005. The original or basement was nonsp monitored fire alarm s smoke detection in co- living areas and in the	eyed as two buildings due to newest sleeping room wing in ne story building with a rinklered. The facility has a system with hard wired orridors and in common to basement. The facility has I had a census of 8 at the					
	(E-Score) using NFP	acuation Difficulty Score A 101A, Alternative afety, Chapter 6, rated the					
_ABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUF	<u> </u>		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 000826

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ULTIPLE CONSTRUCTION LDING 02, 03		(X3) DATE SURVEY COMPLETED	
		15G307	B. WING			11/	19/2013
NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCES SRV INC				STREET ADDRESS, CITY, STATE, ZIP CODE 206 W STATE ST KINGMAN, IN 47952			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From page facility Prompt with ar		K	000			
K 000		cal Surveyor on 11/26/13.	K	000			
	conducted by the Indi	ecertification Survey was ana State Department of with 42 CFR 483.470(j).					
	Survey Date: 11/19/1	3					
	Facility Number: 000 Provider Number: 15 AIM Number: 100249	G307					
	Surveyor: Bridget Bro Specialist	own, Life Safety Code					
	Resource Services In with Requirements fo 42 CFR Subpart 483. and the 2000 edition Protection Association Code (LSC), Chapter	n (NFPA) 101, Life Safety 32, New Residential Board es for the 2005 addition to					
	the addition of a north 2005. The one story has a monitored fire a smoke detection in co	yed as two buildings due to awest sleeping room wing in sprinklered 2005 addition alarm system with hardwired prridors and in all living as the capacity for 8 and had me of this survey.					
	Calculation of the Eva	acuation Difficulty Score					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02, 03		(X3) DATE SURVEY COMPLETED	
	15G307 B. WING				11/19/2013		
NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCES SRV INC				STREET ADDRESS, CITY, STATE, ZIP CODE 206 W STATE ST KINGMAN, IN 47952			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BY THE PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)			SHOULD BE	(X5) COMPLETION DATE		
K 000	Continued From page (E-Score) using NFP Approaches to Life S facility Prompt with a	A 101A, Alternative afety, Chapter 6, rated the	K 00				